

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION</b>	1. TRANSMITTAL NUMBER:  <b>03-41</b>	2. STATE  <b>Louisiana</b>
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE  <b>October 1, 2003</b>	

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN    ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN    ☒ AMENDMENT

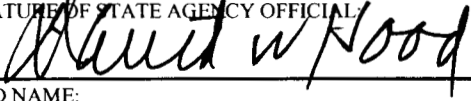
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:  <b>42 CFR 440.130 C</b>	7. FEDERAL BUDGET IMPACT: a. FFY <u>2003</u> <b>(\$326.87)</b> b. FFY <u>2004</u> <b>(\$323.97)</b>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19-B, Item 13.d, Page 3</b>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <b>Same (00-34)</b>

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to reduce all established reimbursement rates for mental health rehabilitation services. This action is necessary in order to avoid a budget deficit in the medical assistance programs.**

11. GOVERNOR'S REVIEW (Check One):


☐ GOVERNOR'S OFFICE REPORTED NO COMMENT    ☒ OTHER, AS SPECIFIED: **The Governor does not review state plan material**  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: <b>State of Louisiana Department of Health and Hospitals 1201 Capitol Access Road PO Box 91030 Baton Rouge, LA 70821-9030</b>
13. TYPED NAME: <b>David W. Hood</b>	
14. TITLE: <b>Secretary</b>	
15. DATE SUBMITTED: <b>December 9, 2003</b>	

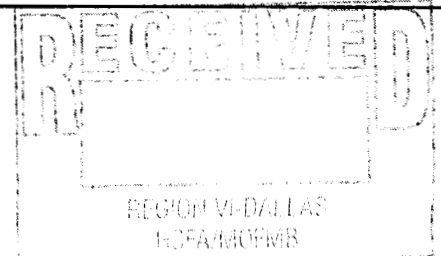
FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:  17 DECEMBER 2003	18. DATE APPROVED:  4 FEBRUARY 2004
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:  1 OCTOBER 2003	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME:  ANDREW A. FREDRICKSON	22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR DIV OF MEDICAID & CHILDREN'S HEALTH

23. REMARKS:



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 4.19-B  
Item 13.d., Page 3

STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

<u>CITATION</u>	Medical and Remedial	2.	Reimbursement for services specified in the 90 day
42 CFR	Care and Services		action strategy plan in the approved MHR Service
447.304	Item 13.d.(cont'd.)		Agreement shall be paid at a flat monthly rate for the
440.130			appropriate frequency schedule (High, Medium, or
			Low Need Services for Children/Youth and Adults),
			which is determined by medical necessity.

Effective October 1, 2003, the reimbursement rate for all established mental health rehabilitation services shall be 99.2 percent of the rates in effect on September 30, 2003 (a .8 percent reduction).

Flat monthly rates are based on estimated number of hours of each service in each frequency schedule (weighted by usage determined by a study of prior history for similar services) and hourly cost of composite services, including all provider costs regardless of location in which services are provided (based on historical reimbursement for those services).

Rates for each frequency schedule are based on 66.6% of the estimated cost of services for the appropriate frequency schedule.

Payment is contingent upon the delivery of 80% of the services contained in the Service Agreement. Reimbursement for the first month will be made after 80% of one-third of the total services have been provided. Reimbursement for the second month will be made after 80% of two-thirds of the total services have been provided. Reimbursement for the third month will be made after 80% of total services have been provided

STATE <u>Louisiana</u>	A
DATE RECD <u>17 Dec 2003</u>	
DATE APD <u>4 Feb 2004</u>	
DATE EFF <u>1 Oct 2003</u>	
HCFA 179 <u>03-41</u>	

TN# 03-41  
Supersedes

Approval Date 4 Feb 2004

Effective Date 1 Oct 2003

TN# 00-34

REPLACES TN# 00-34